

Wisconsin Medicaid and BadgerCare update

May 2004 • No. 2004-42

Wisconsin Medicaid and BadgerCare Information for Providers

To:
Free-Standing End
Stage Renal
Disease Service
Providers
HMOs and Other
Managed Care
Programs

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at dhfs.wisconsin.gov/medicaid/.

PHC 1250

Billing Changes for Free-Standing End Stage Renal Disease Clinics Effective July 1, 2004

Effective for dates of service (DOS) on and after July 1, 2004, Wisconsin Medicaid will require Free-Standing End Stage Renal Disease (ESRD) clinics to indicate on the claim detail the individual dates on which ESRD services are provided.

These billing changes are made in conjunction with the new Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards.

These Medicaid billing changes also occur in conjunction with Medicare's claims processing changes. See the Medicare contingency plan at www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3031.pdf for more information about Medicare's claims processing changes.

If individual DOS are not included on a Medicare crossover claim, providers will need to adjust the Medicaid claim, indicating the individual DOS, and resubmit it for processing by Wisconsin Medicaid.

A provider's claim may be denied or a provider may not receive full Medicaid reimbursement if individual DOS are not submitted.

Providers who have general questions about submitting claims for ESRD services may call Provider Services at (800) 947-9627 or (608) 221-9883.

Electronic Claims

Providers submitting electronic claims using the 837 Health Care Claim: Institutional (837I) format will indicate individual DOS on the claim detail. Wisconsin Medicaid will allow a range of dates on a claim detail only when an identical service is performed on consecutive days. For example, a provider may bill the 0821 revenue code using a date range of July 1, 2004, through July 14, 2004, only if hemodialysis is provided on all of those 14 days.

Paper Claims

Providers submitting paper claims may indicate up to four individual DOS per detail. See Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for a Medicaid-only paper claim sample and Attachment 2 for a Medicare crossover paper claim sample.

Questions pertaining specifically to the 837I format may be directed to the Electronic Data Interchange (EDI) Helpdesk via telephone at (608) 221-9036 or via e-mail at wiedi@dhfs.state.wi.us.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service billing requirements and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

ATTACHMENT 1

Sample UB-92 Medicaid-Only Claim for Free-Standing End Stage Renal Disease

[illegible]

OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

ATTACHMENT 2

Sample UB-92 Medicare Crossover Claim for Free-Standing End Stage Renal Disease

(Attach Medicare remittance advice to claim form.)

| | | | | | | | |
|---|--|--------------------------------|--|------------------------|--|----------------|--|
| IM BILLING HOSPITAL 321 HOSPITAL RD ANYTOWN, WI 55555 (555) 321-1234 | | 2 | | 3 PATIENT CONTROL NO. | | 4 TYPE OF BILL | |
| | | | | 1234JCD | | 721 | |
| 5 FED. TAX NO. | | 6 STATEMENT COVERS PERIOD FROM | | 7 COV D | | 8 N-C-D | |
| | | 070104 072904 | | 13 | | | |
| 12 PATIENT NAME | | | | 13 PATIENT ADDRESS | | | |
| RECIPIENT, IMA H. | | | | | | | |
| 14 BIRTHDATE | | 15 SEX | | 16 MS | | 17 DATE | |
| | | | | | | | |
| 18 HR | | 19 TYPE | | 20 SRC | | 21 D HR | |
| | | | | | | | |
| 22 STAT | | 23 MEDICAL RECORD NO. | | 24 | | 25 | |
| | | | | | | | |
| 26 | | 27 | | 28 | | 29 | |
| | | | | | | | |
| 30 | | 31 | | 32 | | 33 | |
| | | | | | | | |
| 34 | | 35 | | 36 | | 37 | |
| | | | | | | | |
| 38 | | 39 | | 40 | | 41 | |
| | | | | | | | |
| 42 REV. CD. | | 43 DESCRIPTION | | 44 HCPCS / RATES | | 45 SERV. DATE | |
| | | | | | | | |
| 46 SERV. UNITS | | 47 TOTAL CHARGES | | 48 NON-COVERED CHARGES | | 49 | |
| | | | | | | | |
| 1 | | 2 | | 3 | | 4 | |
| 5 | | 6 | | 7 | | 8 | |
| 9 | | 10 | | 11 | | 12 | |
| 13 | | 14 | | 15 | | 16 | |
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| 97 | | 98 | | 99 | | 100 | |

UB-92 HCFA-1450

OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.